

DEVELOPMENTAL DISABILITIES PROGRAM
CHILDREN'S WAIVER SERVICES (0208 WAIVER)
APPLICATION PACKET

INTAKE AND REFERRAL INFORMATION

FAMILY INFORMATION

Individual's Name:	Age:	DOB:
Individual's Social Security Number:	Date of Referral:	
Present Address:		
Individual has: <input type="checkbox"/> Medicaid <input type="checkbox"/> SSI <input type="checkbox"/> Private Insurance		
Medicaid at Risk:		
Parent/Guardian:		
Parent/Guardian Address:		
Home Phone:	Other Phone:	
Parent/Guardian:		
Parent/Guardian Address:		
Home Phone:	Other Phone:	
Is this the: <input type="checkbox"/> Natural Home <input type="checkbox"/> Foster Home <input type="checkbox"/> Other		
Who has legal custody of the child/individual? NAME (S)		

DEVELOPMENTAL DISABILITY INFORMATION

DIAGNOSIS (Attach all appropriate reports/documentation):	
Medical Diagnosis: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, Physician:	
Place: (clinic/hospital, etc.)	
Date:	
Psychology/Educational/Child Study Team Diagnosis: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, Evaluator:	
Place/Agency:	
Date:	
Family Support Specialist:	
<u>CURRENT PLACEMENT INFORMATION:</u> Directions: (check one) <input type="checkbox"/> Out-of-home placement currently <input type="checkbox"/> At risk for out-of-home placement <input type="checkbox"/> Out-of-home placement requested <input type="checkbox"/> No risk for out-of-home placement <input type="checkbox"/> Out-of-home placement discussed	

PARENT/GUARDIAN APPROVAL FORM

As parent/guardian, I/we, _____, after hearing a description of Children's Waiver Services, ☐agree ☐disagree that a referral on _____ may be completed.
(Individual's Name)

If the individual is eligible for services through Children's Waiver Services, the parent/ guardian agree(s) to one of the following for the individual:

(CHECK ONE)

- ☐ Remain in own home
☐ Return to own home
☐ Remain in foster home
☐ Go into foster home
☐ Other:

I/We, _____, ☐agree/☐do not agree to participate in the Children's Waiver Services.

Parent/Guardian Signature:

Date:

Parent/Guardian Signature:

Date:

Witness:

Date:

This packet will be scored based on the information provided by the family and the Family Support Specialist. The score on this packet must be accepted by the screening committee (Children's Waiver Services Policy and Procedures) and may change based on the findings of that committee.

The following continuum of services have been explained *to me*:

- Natural Home
- Foster Home
- Community Home
- Intermediate Care Facility for the Mentally Retarded (ICF/MR)

Parent/Guardian Signature:

Date:

SUMMARY FORMAT – Social History

Completed by:	Title:	Date:
---------------	--------	-------

Please answer each question briefly, providing specific details pertinent to the child's needs.

DESCRIPTION OF CHILD

Child's Name:	DOB:	Age:		
1. Does this child have a diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what is it? Who made the diagnosis?				
2. What level of disability does this child have (describe strengths/abilities and limitations/disabilities)?				
3. What is the level of care for this child (i.e., support needed for daily routines).				
4. Does this child have any medical needs? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, describe the severity, frequency, triggers, and type of intervention needed, including surgeries and hospitalizations.				
5. Please list all of the medications this child is on and what each is for: <table border="0" style="width: 100%;"> <tr> <td style="text-align: center;"><u>Medication</u></td> <td style="text-align: center;"><u>Purpose</u></td> </tr> </table>			<u>Medication</u>	<u>Purpose</u>
<u>Medication</u>	<u>Purpose</u>			
6. Does this child exhibit behaviors that are of concern or are inappropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please list them and note their severity, frequency and what triggers each, if possible:				

- | | |
|----|---|
| 7. | What impact does this child's disability and/or accompanying behaviors or medical challenges have on his/her family (i.e., schedules, employment, finances, relationships, etc.). |
| 8. | Describe the child's typical temperament, interests, and strengths. |

DESCRIPTION OF FAMILY

- | | |
|-----|---|
| 9. | Where does the child live? Describe the residence, list members of the household, and describe any noteworthy dynamics of family members, which impact the child. |
| 10. | What are the natural supports available to this family (extended family, church, community, friends, etc.): |
| 11. | Describe significant family stressors (health, finances, jobs, school, etc.) - both long-term and more recent: |
| 12. | Who has care giving responsibilities for this child? |
| 13. | Describe parents' other roles and responsibilities (i.e., employment and care giving). |

RESOURCES/NEEDS

14.	Does this family have or need any home or vehicle modifications to accommodate their child and his/her disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what?
15.	List or describe pertinent services or supports in place for this family (i.e. services and funding).
16.	What level of DDP services is the family receiving, and how well do they utilize these?
17.	Does this child have a funding source such as insurance, CHIP, or Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, what?
18.	Does this child have any personal financial resources such as a trust fund or inheritance? <input type="checkbox"/> Yes <input type="checkbox"/> No
19.	List the family's "out-of-pocket" expenses for the care of their child.

ADDITIONAL INFORMATION - OPTIONAL

<div>20. List other <u>pertinent</u> information (<u>optional</u>)</div> <div>Additional information in brief letter from family (<u>not required</u>): <input type="checkbox"/>Yes <input type="checkbox"/>No</div> <div>Photograph of child (<u>not required</u>): <input type="checkbox"/>Yes <input type="checkbox"/>No</div>
--

SUPPORTS NEEDED FROM CWS

23. List or describe the needs that will be met by CWS Services.
--

CARE REQUIREMENTS

Revised 07-19-2012

Name:	Date:	Page __ of __
-------	-------	---------------

Include specific details regarding the care provided to assist your family member in the areas of MOBILITY, MEDICAL INTERVENTIONS, DAILY ROUTINES (feeding, dressing, bathing, transportation), and SOCIAL INTERACTIONS.

Task/Behaviors	Time Required *Physical Care *Behaviors	Total Cost Of Care	Cost to Family	Programs & Resources

CARE REQUIREMENTS (continued)

Name: _____	Date: _____	Page __ of __
-------------	-------------	---------------

Include specific details regarding the care provided to assist your family member in the areas of MOBILITY, MEDICAL INTERVENTIONS, DAILY ROUTINES (feeding, dressing, bathing, transportation), and SOCIAL INTERACTIONS.

Task/Behaviors	Time Required *Physical Care *Behaviors	Total Cost Of Care	Cost to Family	Programs & Resources

Totals:

- Number of hours of care required per day all pages: _____
- Cost to family per month: \$_____. Total annual cost to family: \$_____
- Cost of care- all resources: \$_____

STANDARD RESOURCE CHECKLIST

revised 07-19-2012

Use only those items below with * when figuring score; **do not** score items on Resource (Pg 2) with O in the box.

<u>Resource (Pg. 1)</u>	Need	Currently Used	Need Met	CWS Can Meet Need	Please explain if resource is needed & available, why it is not used
COUNSELING					
Family Counseling Services*					
Individual Counseling Services*					
Psychologist*					
HABILITATION					
Adaptive Equipment*					
Assistive Technology*					
Audiological*					
Augmentative Comm.*					
Behavioral Training/Supports*					
Environmental Mod.*					
Habilitation Aide*					
Vehicle Modification*					
Hearing Aid*					
Occupational Therapy*					
Physical Therapy *					
Speech Therapy*					
Telecommunication(TDD)*					
Visual Services*					
Visual Aide/Glasses*					
Vocational Services*					
FINANCIAL					
Private Health Insurance*					
Medicaid*					
ESPDT/Kids Count*					
MEDICAL					
Allergist*					
Dental*					
Medication*					
Otolaryngology*					
Neurological*					
Nutritionist*					
Ophthalmologist*					
Orthopedic*					
Pediatrician*					
Private Duty Nurse*					
Shodair/Genetics*					

<u>Resource</u> <u>(Pg. 1 - continued)</u>	Need	Currently Used	Need Met	CWS Can Meet Need	Please explain if resource is needed & available, why it is not used
OTHER					
Personal Care Assistant*					
Respite*					
Transportation*					
Homemaker*					
PLACEMENT					
Foster Home*					
TOTAL					

TOTALS:

Total number of Needs Met (____)
divided by total number of Needs (____) = Current Resources/Supports (____%).

Total number of CWS Can Meet Needs (____)
divided by number of Needs (____) = Supports Offered by CWS (____%).

**Directions for Giving Crisis Points on Montana Children's Waiver Services Screening
Priority Scoring:**

In order for an individual to be awarded crisis points for "Out of Home Placement" when conducting a screening for Children's Waiver Services the following items must be present and identified in the referral application packet:

- In the Current Placement Information section the "Out of Home placement requested" box must be checked.
- In the Parent/Guardian Approval Form section the "Go into foster home" box must be checked.
- In the Additional Information section the family must submit a letter requesting out of home placement and it must be attached to the referral packet. The FSS must identify in writing current attempts to recruit an alternate placement.
- Children who need immediate placement to a children's or adult group home will be given crisis points if the first three criterion above are met, the referral for the adult or children's group home has been completed and the child's name appears on the waiting list for screening to those services.

Note: Children who are placed out of home in stable environments (examples, foster or in kind placements) do not qualify for out of home crisis points in this category.

One Crisis point related to medical needs may be awarded for any of the three of the following criterion, if all three are met a total of two points maybe awarded:

- The family has no insurance, insurance will end in the next 90 days, insurance is only sometimes available (example, family income qualifies for Medicaid in some months but not others) or insurance is capped and caps have been met/will be met within the next 6 months or family suffers financial hardship because they must refuse salary increases in order to maintain Medicaid (one point maximum).

AND

- The child currently shows less than 70% of identified needs are used due to lack of insurance or inadequate insurance as identified on the Resource Checklist (one point maximum). Used needs are identified as

<u>USED</u>	X	100%
NEEDS		

AND

- The child has less than 30% of his or her needs met currently due to the lack of insurance or inadequate insurance as identified on the Resource Checklist (one point maximum). Unmet needs will be determined by

<u>MET NEEDS</u>		
NEEDS	X	100%

In calculating the above, count only the items checked on the Standard Resource Checklist that are not shaded. Specifically, environmental modifications, habilitation aide, vehicle modifications, TDD, vocational services, private health insurance, Medicaid, ESPDT/Kids Count, personal care, respite, transportation and homemaker are not considered for the purpose of this calculation.

Supports that are needed but not accessed must be clearly described in either the social history or resource checklist sections of the application. Example, if a child/family has an assessed need for counseling that is not currently used, the explanation should indicate 'family not interested at this time' or 'no insurance to meet the need'.

Lack of transportation to meet the child's medical needs is not generally a billable waiver allowance. Medical transportation mileage would require pre-authorization under State Plan Medicaid.

STANDARD RESOURCE CHECKLIST – UNSCORED PORTION (page 2)

Use only those items above with * when figuring score; **do not** score these items with O in the box.

<u>Resource (Pg. 2)</u>	Need	Currently Used	Need Met	CWS Can Meet Need	Please explain if resource is needed & available, why it is not used
COUNSELING					
Other	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
HABILITATION					
Skill Acquisition	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
Other	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
FINANCIAL					
SSI	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
Children's Special Health Serv.	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
Other	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
LEGAL					
Montana Advocacy	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
Self-Sufficiency Trusts	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
Guardianship (Legal Srvcs)	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
Other	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
MEDICAL					
Other Specialist	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
Indian Health Services	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
Public Health Nurse	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
Shriner's Services	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
EDUCATION					
Head Start	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
Home School	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
MSDB Services	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
Private Preschool	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
School District/Special Ed	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
Parenting Class	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
Other	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	
PLACEMENT					
Natural Home	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	

ASSESSMENT INFORMATION

(ATTACH ALL ASSESSMENT REPORTS AND/OR RATING SCALES)

Individual's Name:

DEVELOPMENTAL ASSESSMENTS

Area of Development	Assessment Used	Developmental Age	Percent of Delay
Receptive Language			
Expressive Language			
Fine Motor			
Gross Motor			
Cognitive/Adaptive			
Social			
Self-Help			

Date(s) of Testing:

Age at Testing:

STANDARDIZED ASSESSMENT

Age at Testing:

Standardized Assessment(s) and Date(s):

SUMMARY OF ASSESSMENT RESULTS

Attach annual Psychiatric Evaluation. If this is not available, give information that describes the individual's skills and his/her adaptive and functioning level. Enough information should be given to substantiate if the individual is or is not severely disabled. The assessment summary should include behavioral information, vocational information, and information regarding skills for independent living.

Developmental Severity Rating Scale (DSRS) for CWS Application Process

Part 1: If standard scores for both intelligence and adaptive behavior are present, use both. Compute the average of the two scores (e.g., add the IQ score and the Vineland score together and divide by 2). If only 1 score is present, use that score. For example, use of a standard score *from* an adaptive behavior measure would be sufficient if the child is not able to be assessed for intelligence because they are un-testable.

<u>Rating</u>	<u>Description</u>
0	Standard score above 75
1	Standard scores from 55-70 (can be extended to 75 because of standard error of measurement)
2	Standard scores from 40-54
3	Standard scores from 25-39
4	Standard scores from 0-24

Part 2: As an alternative method for determining a developmental severity rating when a child is untestable, you can obtain an estimate of cognitive development or overall development using a developmental checklist.

The standard score is then computed as follows:

$$\frac{\text{Child's Developmental Age Equivalent} \times 100}{\text{Child's Chronological Age}}$$

Step 1: Use decimal representation of years for all numbers. See examples below:

- a) 3 years, 2 months = 3.17 years
- b) 8 months .67 years
- c) 2 years, 11 months = 2.92 years

Step 2: If you have several scores, compute the arithmetic average. See examples below:

- a) Cognitive development = 1 year, 1 month = 1.08 years
 - b) Motor skills = 1 year, 6 months = 1.5 years
 - c) Self- help skills 9 months = .75 years
 - d) Social skills = 10 month = .83 years
- Average = $1.08 + 1.5 + .75 + .83 = 4.16$ divided by 4 = 1.04

Step 3: Assume child is 6 years, 2 months.

$$\text{Standard score} = \frac{1.04}{6.17} \times 100 = .17 \times 100 = 17$$

Step 4: Disability Rating = 4 (from table above)

Check the numbers of the behavioral and medical levels that best describe the individual.	
Behavioral Severity Rating Scale (BSRS)	Medical Severity Rating Scale (MSRS)
0 Positive Adjustment -- Child gets along well with others and accepts daily responsibilities at a level that is consistent with their overall disability. No behavioral symptoms are noted.	0 Positive Physical Health -- Child has good health and typically requires only routine well-check visits with physician. No medical symptoms are noted. Absent or Minimal Symptoms -- Medical concerns are within normal limits for age and developmental levels. Example: Child occasionally requires treatment for colds, ear infections, etc.
1 Absent or Minimal Symptoms -- Concerns are within normal limits for age and developmental levels. Example: Child occasionally has a minor tantrum when frustrated.	1 Slight Symptoms -- Symptoms are transient and related to known causes. Only slight impairment in family, school, or social adjustment is noted. Example: A child who is normally healthy has significant allergy problems in the summer or is sick 2-4 times during the flu season. Both examples require significant medical treatment.
2 Slight Symptoms -- Symptoms are transient and related to known stresses. Only slight impairment in family, school, or social adjustment and functioning is noted. Example: A child who normally gets along with others becomes more non-compliant, more argumentative, or more easily frustrated following a surgery, parental divorce, or other stressful life change.	2 Mild Symptoms -- Child is able to function at an acceptable level, but some consistently mild medical difficulties are noted on a weekly basis which negatively impact the child's family, school, or social adjustment and functioning. Example: Child requires a special diet or has seizures that are only partially controlled with medical treatment. Symptoms are not life-threatening.
3 Mild Symptoms -- Child still functions at an acceptable level, but some consistently mild behavior difficulties are present on a weekly basis which negatively impact the child's family, school, or social adjustment and functioning. Example: A child usually resists following directions, but will eventually cooperate if the caregiver is consistent and does not give in.	3 Moderate Symptoms -- Significant medical/physical problems of a moderate severity are present on a daily basis which negatively impact the child's family, school, or social adjustment and functioning. Example: Brittle diabetic, poorly controlled seizures, uncontrolled allergies. Daily medical care is provided by parent. Symptoms are generally not life-threatening.
4 Moderate Symptoms -- Significant behavior problems of a moderate severity are present on a daily basis which negatively impact the child's family, school, or social adjustment and functioning. Example: A child exhibits consistent tantrums, non-compliance, or social withdrawal in most environments.	4 Severe Symptoms -- Severe medical/physical challenges are present on a daily basis which negatively impact the child's family, school, or social adjustment and functioning. Example: Uncontrolled seizures, non-ambulatory child requiring use of a wheel chair and adaptive equipment. Daily medical care is provided by parent and frequent consultation with medical professionals and therapists is required. Symptoms are only rarely life-threatening.
5 Severe Symptoms -- Cluster 1: Severe behavior challenges are present on a daily basis which negatively impact the child's family, school, or social adjustment and functioning. Example: Cooperation is virtually nil. It is difficult for caregivers to connect with the child in a positive interaction. Cluster 2: Child presents extreme concerns in terms of safety or vulnerability to self, or infrequent, but very intense behavioral symptoms. Examples: Child runs away from caretaker or home on a fairly regular basis, or engages in sexual acting out of a serious nature.	5 Occasional Medical Crises -- Occasional medical crises or symptoms (e.g., 2-4 times/year) are noted in combination with the severe symptoms of #5 above. Example: A child with severe symptoms (see #5 above) also requires occasional hospitalizations or E.R. visits to treat medical crises or life-threatening symptoms (e.g., chronic upper respiratory infections with frequent pneumonia, feeding tube).
6 Occasional Danger -- Occasional violence (e.g., 1-2 times/month) towards self or others, or destruction of property are noted in combination with the severe symptoms of #5 above. Example: A child with severe symptoms (see #5 above) also engages in occasional hurting of self or others causing significant injury requiring medical attention (e.g., head banging that causes bruises and swelling, bruising or breaking the skin on others) or occasionally throwing and breaking toys or minor household objects.	6 Intermittent Medical Crises -- Intermittent medical crises or life threatening symptoms (e.g., monthly) are noted in combination with the severe symptoms of #5 above. Example: A child with severe symptoms (see #5 above) also requires frequent hospitalizations or E.R. visits, or extreme home treatments (e.g., oxygen, suctioning of secretions, tracheostomy care, or ventilator) with frequent complications and regular medical consultation required.
7 Intermittent Danger -- Intermittent violence (e.g., 1-2 times/week) towards self or others, or some serious destruction of property (1-2 time/week) are noted in combination with the severe symptoms of #5 above. Example: A child with severe symptoms (see #5 above) also engages in intermittent hurting of self or others causing significant injury requiring medical attention (e.g., head banging that causes bruises and swelling, bruising or breaking the skin on others) or intermittent damage to property in the range of \$50.00 - \$100.00.	7 Persistent Medical Crises -- Weekly medical crises or life-threatening symptoms are noted in combination with the severe symptoms of #5 above. Example: Child is very medically fragile and requires extreme home treatments (e.g., monitoring heart rate and oxygenation levels, complex medication dispensation, life support systems) with daily complications and ongoing medical consultation required.
8 Persistent Danger -- The child exhibits recurrent violence towards self or others, extreme destruction of property, or other severe, disruptive behavior problems that are present virtually every day. These are combined with the severe symptoms described in #5 above. Example: A child with severe symptoms (see #5 above) also engages in daily hurting of self or others causing significant injury requiring medical attention (e.g., head banging that causes bruises and swelling, bruising or breaking the skin on others) or frequent damage to property in excess of \$100.00.	<div style="text-align: center;"> N A  </div>

BDRS SCORING SUMMARY SHEET- LEVEL OF DISABILITY For CWS Application

Child/client's Name: _____

Rater's Name: _____

Date of Rating: _____

BEHAVIORAL SEVERITY RATING:

Numerical Rating: _____

Numerical Rating divided by 2: _____

Behavioral Rating: (Mild 1, Moderate 2, Severe 3, Profound 4) _____

Comments (Provide specific examples or description of behavior problems as documentation of rating.)

MEDICAL SEVERITY RATING:

Numerical Rating: _____

Numerical Rating divided by 2: _____

Medical Severity Rating: (Mild 1, Moderate 2, Severe 3, Profound 4) _____

Comments (Provide specific examples or description of medical problems as documentation of rating.)

DEVELOPMENTAL SEVERITY RATING:

Numerical Rating: _____

Developmental Severity Rating: (Mild 1, Moderate 2, Severe 3, Profound 4) _____

Comments (Provide specific examples or description of developmental problems as documentation of rating.)

Applicant's Name: _____

Date: _____

Finalizing the Disability Rating:

Putting It All Together

Step 1: Obtain disability ratings for each area, i.e., behavioral, developmental, and medical disability rating scales.

Step 2: Example:

- 1) Behavioral Disability Rating = 3.5 (Do not round off)
Behavioral Disability Level = Severe to Profound (From table on page 1 of Developmental Disability Rating Scale)
- 2) Medical Disability Rating = 3
Medical Disability Level = Severe (From table)
- 3) Developmental Disability Rating = 1
Developmental Disability Level = Mild (From table)

Step 3: Use the most severe rating in any one area as an initial estimate of Disability level.

Example: From Step 2 – Behavioral Disability Rating = 3.5
= Severe to Profound

Step 4: If other areas are more severe than a mild rating, add .5 point for each area.

Example: Step 2, #2 – Medical Disability Rating = 3
= Severe = add .5

Step 2, #3 – Developmental Disability Rating = 1
= Mild. So add 0 points

Step 5: Final Disability Level = $3.5 + .5 = 4$ = Profound (From table)

Note: Highest score possible = $4 + .5 + .5 = 5$

This would be a child who has a severe-profound disability in one area and a moderate or lower disability in both of the other two areas.

Step 6: Use the score from step 5 (do not round off) as the child's disability level for the prioritization scale (see level of disability sections).

Level of Disability Score: _____

0208 CHILDREN'S WAIVER SERVICES "STRESS QUESTIONNAIRE"

INSTRUCTIONS: THIS QUESTIONNAIRE DEALS WITH YOUR FEELINGS ABOUT A MEMBER OF YOUR FAMILY. THERE ARE MANY BLANKS ON THE QUESTIONNAIRE. IMAGINE THE PERSON'S NAME FILLED IN ON EACH BLANK. GIVE YOUR HONEST FEELINGS AND OPINIONS.

PLEASE ANSWER ALL OF THE QUESTIONS, EVEN IF THEY DO NOT SEEM TO APPLY. IF IT IS DIFFICULT TO DECIDE **TRUE** OR **FALSE**, ANSWER IN TERMS OF WHAT YOU OR YOUR FAMILY FEEL OR DO MOST OF THE TIME.

THE QUESTIONS SOMETIMES REFER TO AN OLDER OR YOUNGER PERSON, OR SOMEONE WHO HAS PROBLEMS YOUR FAMILY MEMBER DOES NOT HAVE. NEVERTHELESS, THEY CAN BE ANSWERED **TRUE** OR **FALSE**.

DO NOT WRITE ON THE QUESTIONNAIRE. SIMPLY IMAGINE YOUR RELATIVE'S NAME IN THE BLANKS PROVIDED. MARK THE ANSWERS ON THE ANSWER SHEET.

1. _____ demands that others do things his/her way more than is necessary.
2. _____ is cared for equally by all members of our family.
3. Members of our family praise each other's accomplishments.
4. The doctor sees _____ at least once a month.
5. _____ would be in danger if he/she could get out of the house or yard.
6. People who don't have the problems we have don't have the rewards we have either.
7. Other members of the family have to do without things because of _____.
8. If _____ were more pleasant to be with, it would be easier to care for him/her.
9. I don't worry too much about _____'s health.
10. Our family agrees on important matters.
11. The constant demands to care for _____ limit growth and development of someone else in our family.
12. I worry about what will happen to _____ when I can no longer take care of him/her.
13. I am able to leave _____ alone in the house for an hour or more.
14. _____ is limited in the kind of work he/she can do to make a living.
15. I have given up things I have really wanted to do in order to care for _____.
16. I would not want the family to go on vacation and leave _____ at home.
17. There is no way we can possibly keep _____ in our house.

18. _____ can feed himself/herself.
19. As the time passes, I think it will take more and more to care for _____.
20. We can afford to pay for the care _____ needs.
21. It bothers me that _____ will always be this way.
22. _____ uses special equipment because of his/her handicap.
23. _____ is easy to live with.
24. The doctor sees _____ at least once a year.
25. Wheelchairs or walkers have been used in our house.
26. Caring for _____ has been a financial burden for our family.
27. I worry that _____ may sense that he/she does not have long to live.
28. We enjoy _____ more and more as a person.
29. _____ knows his/her own address.
30. _____ is aware of who he/she is (for example - male, 14 years old)
31. Sometimes I need to get away from the house.
32. Having to care for _____ has enriched our family life.
33. _____ doesn't do as much as he/she should be able to do.
34. Our family has been on welfare.
35. We take _____ along when we go out.
36. _____ is accepted by other members of the family.
37. _____ spends time at a special day center or in special classes at school.
38. Our family's income is more than average.
39. Caring for _____ gives one a feeling of worth.
40. One of us has had to pass up a chance for a job because _____ could not be left without someone to watch him/her.
41. I worry about how our family will adjust after _____ is no longer with us.
42. The part that worries me most about _____ going out on his/her own is his/her ability to make a living.

43. I worry about what will be done with _____ when he/she gets older.
44. _____ can get around the neighborhood quite easily.
45. There is a lot of anger and resentment in our family.
46. Our family has managed to save money or make investments.
47. We own or are buying our own home.
48. I am afraid _____ will not get the individual attention, affection, and care that he/she is used to if he/she goes somewhere else.
49. _____ is better off in our home than somewhere else.
50. _____ can describe himself/herself as a person.
51. It is easy to keep _____ entertained.
52. In the future, _____ will be more able to help himself/herself.
53. _____ needs a walker or a wheelchair.
54. I have become more understanding in my relationship with people as a result of _____.
55. _____ cannot get any better.
56. Outside activities would be easier without _____.
57. My family understands the problems I have.
58. I am pleased when others see that my care of _____ is important.
59. We can hardly make ends meet.
60. Members of my family are able to discuss personal problems.
61. Most of _____'s care falls on me.
62. _____ is very irritable.
63. It is easy for me to relax.
64. I rarely feel blue.
65. _____ can walk without help.
66. Because _____ uses special equipment and facilities, it is difficult to take him/her out.

ANSWER SHEET
0208 CHILDREN'S WAIVER SERVICES STRESS QUESTIONNAIRE

FOR EACH ANSWER:
FILL IN THE ○ UNDER T FOR **TRUE**, OR
FILL IN THE ○ UNDER F FOR **FALSE**

EXAMPLE: T F

21	●	○
22	○	●
23	●	○

	T	F		T	F		T	F		T	F		T	F		T	F
1	○	○	13	○	○	25	○	○	37	○	○	49	○	○	61	○	○
2	○	○	14	○	○	26	○	○	38	○	○	50	○	○	62	○	○
3	○	○	15	○	○	27	○	○	39	○	○	51	○	○	63	○	○
4	○	○	16	○	○	28	○	○	40	○	○	52	○	○	64	○	○
5	○	○	17	○	○	29	○	○	41	○	○	53	○	○	65	○	○
6	○	○	18	○	○	30	○	○	42	○	○	54	○	○	66	○	○
7	○	○	19	○	○	31	○	○	43	○	○	55	○	○			
8	○	○	20	○	○	32	○	○	44	○	○	56	○	○			
9	○	○	21	○	○	33	○	○	45	○	○	57	○	○			
10	○	○	22	○	○	34	○	○	46	○	○	58	○	○			
11	○	○	23	○	○	35	○	○	47	○	○	59	○	○			
12	○	○	24	○	○	36	○	○	48	○	○	60	○	○			

ANSWER SHEET
CHILDREN'S WAIVER SERVICES STRESS QUESTIONNAIRE

FOR EACH ANSWER:

FILL IN THE ○ UNDER T FOR **TRUE**, OR

FILL IN THE ○ UNDER F FOR **FALSE**

EXAMPLE: T F

21	●	○
22	○	●
23	●	○

	T	F		T	F		T	F		T	F		T	F		T	F
1	○	○	13	○	○	25	○	○	37	○	○	49	○	○	61	○	○
2	○	○	14	○	○	26	○	○	38	○	○	50	○	○	62	○	○
3	○	○	15	○	○	27	○	○	39	○	○	51	○	○	63	○	○
4	○	○	16	○	○	28	○	○	40	○	○	52	○	○	64	○	○
5	○	○	17	○	○	29	○	○	41	○	○	53	○	○	65	○	○
6	○	○	18	○	○	30	○	○	42	○	○	54	○	○	66	○	○
7	○	○	19	○	○	31	○	○	43	○	○	55	○	○			
8	○	○	20	○	○	32	○	○	44	○	○	56	○	○			
9	○	○	21	○	○	33	○	○	45	○	○	57	○	○			
10	○	○	22	○	○	34	○	○	46	○	○	58	○	○			
11	○	○	23	○	○	35	○	○	47	○	○	59	○	○			
12	○	○	24	○	○	36	○	○	48	○	○	60	○	○			

STRESS QUESTIONNAIRE SCORE SHEET FOR CWS

Directions: Compare the answer sheet with the T/F indicators below. If the family member's response matches the T/F indicated for each question, make a tally mark in the box to the right of the T/F for that number. If more than one family member completed the stress test, you need only compare the questions in which a tally was NOT received by the previous family member. There is a maximum of ONE (1) tally per question.

When you are finished scoring the stressors, count the number of tallies marked in each row and record that number in the Total Pts box. A category is considered "stressful" if four (4) or more tallies were indicated.

Dependency & Management:

#1	#8	#23	#33	#51	#62	Total Pts
T	T	F	T	F	T	

Cognitive Impairment:

#5	#13	#29	#30	#44	#50	Total Pts
T	F	F	F	F	F	

Family Opportunity:

#7	#11	#15	#26	#40	#56	Total Pts
T	T	T	T	T	T	

Life Span:

#12	#14	#21	#37	#42	#43	Total Pts
T	T	T	T	T	T	

Family Disharmony:

#3	#10	#36	#45	#57	#60	Total Pts
F	F	F	T	F	F	

Personal Reward:

#6	#28	#32	#39	#54	#58	Total Pts
F	T	F	F	F	F	

Terminal Illness:

#9	#19	#27	#41	#52	#55	Total Pts
F	T	T	T	F	T	

Physical Limitations:

#18	#22	#25	#53	#65	#66	Total Pts
F	T	T	T	F	T	

Financial Stress:

#20	#34	#38	#46	#47	#59	Total Pts
F	T	F	F	F	T	

Institutional Care:

#4	#16	#17	#35	#48	#49	Total Pts
T	F	T	F	F	F	

Personal Burden:

#2	#24	#31	#61	#63	#64	Total Pts
F	T	T	T	F	F	

CHILDREN'S WAIVER SERVICES - PRIORITIZATION

It is assumed that individuals placed on the prioritized waiting list for CWS services meet eligibility requirements for these services. An individual must be eligible for Medicaid in the State of Montana by being a Montana Resident and U.S. Citizen, and by not having significant unearned income or assets. An individual must be under the age of 22 years and have a developmental disability with intensive needs. Intensive needs can include one or more of the following: a) extreme deficiencies in self-care and daily living skills as compared to age peers; b) significant maladaptive social and or interpersonal behavior patterns which require ongoing supervised program of intervention; c) severe medical or health related problems such as sensory or physical deficits requiring substantial care. The individual must meet Medicaid eligibility requirements and must be determined eligible by the Quality Improvement Specialist. CWS services are intended to be provided to individuals who without enhanced services would be extremely difficult to maintain in their home.

PRIORITIZATION SCALE

Review the items in the 3 categories listed below and rate the individual seeking services based on the information available, total the points. These points will be added to either the Less Restrictive Placement screening tool or the At Risk for More Restrictive Placement screening tool, dependent on which tool is being utilized.

TOTAL POINTS

- **Current Resources/Supports**
Meet less than 50% of needs (3 points)
Meet 50-80% of needs (2 points)
Meet 80-100% of needs (1 point)
- **CWS Supports**
Meet 80-100% of needs (3 points)
Meet 50-80% of needs (2 points)
Meet less than 50% of needs (1 point)
- **In Home Care Requirements**
More than 8 hours per day (3 points)
Between 3 and 8 hours per day (2 points)
Less than 3 hours per day (1 point)

At Risk for More Restrictive Placement

- **Level of Disability**
Mild functional impairment resulting from medical developmental and/or behavioral characteristics (1 point)
Moderate functional impairment resulting from medical, developmental and/or behavioral characteristics (2 points)
Severe functional impairment resulting from medical, developmental and/or behavioral characteristics (3 points)
Profound functional impairment resulting from medical, developmental and/or behavioral characteristics (4 points)
- **Family Stress**
Three or less categories marked stressful on the "Stress Questionnaire", or a total score of 30 or less (1 point).
Four categories marked stressful on the "Stress Questionnaire", or a total score of less than 40 (31-39) (2 points).
Five categories marked stressful on the "Stress Questionnaire", or a total

score of 40 or above (3 points).

- Crisis
At risk of out of home placement (3 points)
Financial stress due to child's medical needs (2 points)

Less Restrictive Placement

- Level of Disability
Mild functional impairment resulting from medical, developmental and/or behavioral characteristics (1 point)
Moderate functional impairment resulting from medical, developmental and/or behavioral characteristics (2 points)
Severe functional impairment resulting from medical, developmental and/or behavioral characteristics (3 points)
Profound functional impairment resulting from medical, developmental and/or behavioral characteristics (4 points)
- Potential For Less Restrictive Placement
Natural /relative or trained foster family placement not appropriate or is not available (1 point)
Natural /relative or trained foster family placement may be available (2 points)
Natural /relative or foster family is available (3 points)
- Crisis
Current living arrangements are inappropriate and not the least restrictive setting (3 points)
Financial stress due to child's medical needs (2 points)

Description of Unusual Circumstances - Unique to a Particular Individual

Completed by the QIS Screening Committee

Applicant: _____

Date : _____

Because of other extenuating circumstances, **and in the absence of other paid or unpaid services or supports**, 1-3 points may be added to address unusual variables unique to a particular individual that meet the intent of 37.34.308 (ARM). The following five major categories are to be utilized when considering the possibility of awarding points for extenuating circumstances. These areas are described below:

- | | UC Points (by QIS) |
|--|--------------------|
| 1. Medical - A terminal illness diagnosis or a severe, chronic, debilitating illness in any immediate family member (parent or sibling) and impacts the ability of the caregiver to provide necessary assistance to the child in the service. | |
| 2. Disability - A caregiver or sibling has a significant disability and impacts the ability of the caregiver to provide necessary assistance to the child in the service. | |
| 3. Legal issues – Examples would include abuse, domestic violence, DFS/APS involvement, incarceration of parent or guardian. Could also include if family is split due to child's medical or behavioral issues, family is unable to meet the child's basic medical needs without Medicaid support. Only in so far as it impacts the care of the child. | |
| 4. Catastrophic incidents – Examples would include a natural disaster to the primary residence, or the recent death of a parent or sibling. The child's daily living activities are significantly affected specific to the child's disability. | |
| 5. Geographical barriers – A family lives 100 or more miles, one way, from medical and other therapy services that are routinely needed by the child and /or may be isolated and stranded routinely during winter months. | |

TOTAL POINTS (maximum of 3 points)

After the information in the above categories is identified and discussed, the screening team will award points according to the level of impact on the client and/or family.

There can be only one point awarded per category for a maximum total of three points.

Note to FSS: On the next page, please briefly identify any unusual circumstances in this family that might justify points as identified above.

FSS brief description of unusual circumstances in the family that would justify points being added to the child's score by the QIS Screening Committee:

FSS name:		Applicant:		Date:
Category		Brief Description		
1. Medical				
2. Disability				
3. Legal Issues				
4. Catastrophic Incidents				
5. Geographical Barriers				

Montana Children's Waiver Services Screening Priority Scoring

NAME:

RATER:

DATE:

Criteria

Possible Points

Scores

Current Resources / Supports

Meets Less Than 50% of Needs

3

Meets 50 – 80% of Needs

2

Meets 80 – 100 % of Needs

1

CWS Supports

Meets 80 - 100% of Needs

3

Meets 50 – 80% of Needs

2

Meets Less Than 50% of Needs

1

In Home Care Requirements

More than 8 hours per day

3

Between 3 and 8 hours per day

2

Less than 3 hours per day

1

At Risk for More Restrictive Placement

Family Stress

Five categories marked stressful or a total score of **over 40**

3

Four categories marked stressful or a total score **less than 40 but more than 30**

2

Three or less categories marked stressful or a total score of **30 or less**

1

Crisis

At Risk for Out-of-Home Placement

3

Financial Stress due to child's **medical** needs

2

Level of Disability Rating From other page

Total Service Provider Score

Unusual Circumstances From other page (QIS generated score)

Priority Ranking Score Total

Date

Comments:

CWS Application Packet Checklist

Name: _____ Date Recd.: _____

Service Provider: _____

Check box		Page #(s)
	Intake and Referral Information Page	1
	Parent/Guardian Approval	2
	Summary Format – Social History	3 – 5
	Care Requirements	6-7
	Standard Resource Checklist	8-10
	Assessment Information	11
	BDRS Scoring Summary Sheet	14
	Stress Questionnaire Score Sheet	21
	Prioritization Summary	22-23
	Unusual Circumstances Points (if applicable, may be included in Summary Page)	24
	FSS Description of Unusual Circumstances	25
	CWS Scoring Tool (Excel)	26
	Mini-MONA	
	Wait List Change Form (WLCF)	

Follow-up:

QIS(initials)

Date: